Analyzing Trade-offs and Making Decisions
A Staffing and Workload Webinar

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October 30, 2019
The Center to Advance Palliative Care

NATIONAL SEMINAR

NOVEMBER 14-16, 2019
Atlanta Marriott Marquis

Pre-Conference Workshops:
Boot Camp and Payment Accelerator

WEDNESDAY, NOVEMBER 13
Join us for upcoming CAPC events

➔ Upcoming Webinars:
  – Advancing the Field of Pediatric Palliative Care
    Friday, November 6 at 11:00am ET
  – An Interdisciplinary Panel Discussion about Staff Changes and Workload Management (A Staffing and Workload Webinar)
    Thursday, December 12 at 12:30pm ET

➔ Virtual Office Hours:
  – Improving Team Effectiveness
    Thursday, October 31 at 2:00pm ET
  – Measurement for Community Palliative Care
    Tuesday, November 5 at 2:00pm ET

Register at www.capc.org/events/
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Learning Objectives

➔ Identify principles that can help programs achieve growth goals and secure associated resources

➔ Describe four factors that can impact staffing and workload planning across settings

➔ Understand how to analyze staffing and workload trade-off decisions
Survey

-> Based on your experience, what have been the biggest factors that have impacted staff you needed and how many patients your team could see? (select up to 3)

- Mix and complexity of patients
- Geography (e.g. location of ICU, driving distance)
- Team composition (do you have a triage role?)
- Skill and experience of team
- Role of palliative care service (co-management, consult only)
- Presence of learners
- Budget (driving what you have available to work with)
- wRVU targets / expectations
Common Questions…

➔ What are wRVU’s (worked Relative Value Unit) and how do they relate to productivity targets for my team?
➔ How many consults should an MD, APP, or any team member see each year?
➔ What is the right staffing model?
➔ And given palliative care is a team sport…how many patients can a team care for?
The Answer…

“It depends…”

➔ Staffing mix - do you have an RN coordinator, dedicated social worker, etc.
➔ Size and complexity of the organization - large hospital, multiple sites, home
➔ Integrated or not
➔ Setting and geography – travel time
➔ Learners
➔ Others….
Interdependent Variables Impact Program Design, Staffing, and Volume

Plus organizational factors such as:
✓ Organizational home
✓ Degree of integration into hospital, system, etc.

TIP: It is important to match service promises with staffing.
Fundamental Strategies to Consider When Making Staffing and Workload Decisions and Trade-Offs
## 1: Establishment of Organizational Culture and Mission

| Clarify the purpose and scope of the program | - You can get pulled in many directions – set boundaries |
| Define the role of each setting | - Who are you serving in the clinic or home and why are you there? |
| Partners and stakeholders | - Can you partner and share resources?  
- What do your referring partners need from you? |
| Bottom Line | - There are limited resources - work with what you have  
- Are you demonstrating impact and value to your funders? |
## 2: Understand Challenges to and Plan for Stable Staffing

| Limited workforce | • Assess and develop the skills of the staff you have  
|                   | • Be creative and thoughtful about recruitment |
| Workload distribution | • Establish ranges for workload (e.g. 2-4 new consults)  
|                     | • Monitor individual/team thresholds day-to-day |
| Isolation & burnout | • Maintain connections to the team and communicate  
|                   | • Consider risks of 100% clinical time expectations |
| Retirements & planned transitions | • Start planning now for a known transition  
|                           | • Expect some % of turnover |
3: Assess Volume and Staffing via Strategy (revisiting Needs Assessment)

- **Changing priorities**
  - Has there been a growth or reduction in referrals from one disease type or referral source? Why?

- **Changing partners**
  - Are there new community-based services?
  - Is there a new group practice or hospital?

- **Altering target population and corresponding resource allocation**
  - Do you need a team for a new geography or unit?
  - Does your team have the skills needed?

**TIP:** Continuously work to understand what stakeholders need.
4: Continuously Assess the Team to Optimize Skills and Strengths

- Capitalize on team members’ strengths and passions
  - Right team member at the right time with the right patient

- Transparency
  - Create safe space for team members to ask for help and offer help in high or low volume periods

- Resiliency/Support
  - Take time for team and individual health
  - Be conscious of burnout and stress in peak periods
Case Example:
Lehigh Valley Health Network
Programmatic design via Needs Assessment in 2006

A vehicle for network culture change.
Strategic integration and growth support patients with serious illness within our network.

Integrated Palliative Care Program

Inpatient
Office/Clinic
Home

Hospice and palliative medicine fellowship
Clinical and administrative dyad leadership structure
Budgeting Considerations

→ MD and CRNP Benchmarks are inpatient, but we use them for both inpatient and outpatient

→ 2018 AMGA, MGMA, SCA wRVU benchmark weighted avg:
  – MD median = 2248, 65\textsuperscript{th} = 2549
  – CRNP median = 1894, 65\textsuperscript{th} = 2177

→ Used to be median, now budget at 65\textsuperscript{th}-90\textsuperscript{th} percentile wRVU’s

→ New staff budgeted at 85% of median

→ No SW or LPC billing
Budgeting Considerations (cont’d)

➔ Visits/revenue based on historical billing not benchmarks
➔ All wRVU targets are budgeted per individual provider, but we are held accountable as roll-up
➔ Home-based CRNP’s are between 65\textsuperscript{th} and 90\textsuperscript{th} percentile of inpatient benchmarks
➔ CAPC Impact Calculators for inpatient and outpatient used when accounting for deficit
➔ Hospital benefits from inpatient financial impact, insurance companies benefit from outpatient financial impact
LVHN Inpatient Palliative Medicine Team

Inpatient partnership with hospitalists and sub-specialists

Consult service with 4 MD’s, 4 CRNP’s, 1 LCSW, 1 LPC, 1 RN, chaplain

Covering 2 hospitals + Tele to outlying site

3,000 consults/year

50-90\textsuperscript{th} percentile wRVU generation

Inpatient revenue covers 50\% of total cost
Inpatient LVHN Guiding Principles to Manage Workload

→ MD or CRNP + LCSW/LPC/Chaplain/RN = clinical team
→ MD/CRNP see all consults due to culture of provider billing and clinical partnership
→ Triage consults to identify professional expertise needs
→ Schedule based on historical volume
→ RN monitors day-to-day volume of each hospital for resource needs
→ Keep people whole!
→ Build in connections during the day
→ Maintain IDT schedule
Inpatient Guiding Principles for High-Volume Days (M-F)

➔ Triage of follow-up visits--and on rare occasion initial consult--may be done by LCSW/LPC/Chaplain/RN depending on clinical needs

➔ Cut-off time or max number of consults set

➔ Some may be left for the following day, preferably not Fridays
Inpatient Guiding Principles for High Volume Weekend Coverage

➔ Ongoing schedule includes limited staffing that covers both weekend days and two sites
➔ Triage acuity of consults to assess urgency
➔ Set max hours or consults per day
➔ Only go to one site/day
LVHN Outpatient OACIS Team

Home-Based practice + Office-Based practices (growing)

Partnership with PCP’s and sub-specialists

Co-management consult service with 7 CRNP’s, 1 LCSW, 2 RN’s, 2 MA’s

Covering 750 square miles

1800 unique patients/year

75-90\textsuperscript{th} percentile wRVU generation

Outpatient revenue covers 60\% of total cost
Case Study: Home-Based Practice

➔ Census target of 100 per CRNP; cap of 125 per CRNP
➔ RN’s partner with 3 CRNP’s to manage population
➔ MA’s support home-based and office
➔ Map/regions contract and expand with network need and staffing
➔ Each CRNP has designated region, co-managed with another CRNP
➔ Coordinate time off with partner
➔ Primary focus preventive, minimal urgent visits
Outpatient Guiding Principles for Managing Home-Based Volume

➔ If CRNP is out, RN’s triage scheduled visits to assess acute needs
➔ Alternate CRNP is consulted, makes visit if possible
➔ RN reschedules visits
Outpatient Guiding Principles for Managing Home-Based Volume

→ Social Worker
  – Consultant to the CRNP’s
  – Case management/brief counseling
  – Connects with all other social workers in the network to assure one plan of care and obtain supports
  – When absent, clinical support staff triages needs and forwards to other network social workers
Case Study: Integrated Office Practice

→ Organizational Home: Physician Group
→ Major stakeholders: Sub-specialist
→ Consultative/Co-management role
→ Population
→ Regionalization
→ Focus/scheduling of visits
→ Use of support staff
→ Scheduling challenges
<table>
<thead>
<tr>
<th>Needs Assessment is the roadmap</th>
<th>Stakeholder goals guide the mission</th>
<th>Seek support and guidance from partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collaborate with partners on metrics, present dashboard regularly to demonstrate progress</td>
<td>Back-up clinical site for slow am or pm slots</td>
<td>MA functions as quarterback to manage multiple sites</td>
</tr>
</tbody>
</table>
Managing Barriers

- Revisiting Needs Assessment
- Re-aligning goals with stakeholders
- Open dialogue with the team regarding changing priorities
- Allow for non-billable time
The Math

Example Staffing and Workload Modeling Tool for Team-based Staffing
Examples of Trade-offs and Variables That Will Impact Your Staffing and Workload Plans

Example A:
In a co-management vs. consult only model:
- Likely more visits for a longer duration
- Expect fewer new consults due to capacity being used in co-management follow up visits

Example B:
Patient vs. provider convenience
- Narrow geographic coverage maximizes staff time but may not be as easily integrated into more patient’s overall care
- Consider creative solutions such as 1st visit in person followed by telephone follow up
**TEAM Staffing and Workload Model**

<table>
<thead>
<tr>
<th>Staffing Mix</th>
<th>Scenario 1 Lower follow up frequency</th>
<th>Scenario 2 Moderate follow up frequency</th>
<th>Scenario 3 Higher follow up frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>MD</td>
<td>0.5</td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td>APP</td>
<td>2.0</td>
<td>2.5</td>
<td>3.0</td>
</tr>
<tr>
<td>SW</td>
<td>1.0</td>
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<tr>
<td>...</td>
<td></td>
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</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

**Volumes**

<table>
<thead>
<tr>
<th></th>
<th>Scenario 1 Lower follow up frequency</th>
<th>Scenario 2 Moderate follow up frequency</th>
<th>Scenario 3 Higher follow up frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>New</td>
<td>500</td>
<td>400</td>
<td>300</td>
</tr>
<tr>
<td>Follow-up</td>
<td>1300</td>
<td>1500</td>
<td>1700</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1800</td>
<td>1900</td>
<td>2000</td>
</tr>
</tbody>
</table>

**Factors:**

- Drive time
- Documentation time
- New v follow up mix
- Capacity per day
- PTO/CE
- NO SHOWs

**HOME-BASED EXAMPLE**
Thank you!

Questions and Discussion
How to Submit Questions

Please type your question into the questions pane on your WebEx control panel.